What's New in PTSD Treatment

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October 10, 2022

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PTSD and Complex PTSD

Who Are We Kidding?

Complex PTSD

Complex psychological trauma results from "exposure to severe stressors that (1) are repetitive or prolonged, (2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and (3) occur at developmentally vulnerable times in the victim's life.

Ford and Courtois, 2009

What Is Complex PTSD?

- The psychological effects of chronic and cumulative traumas
- Results from interpersonal victimization, multiple traumatic events, and/or traumatic exposure of prolonged duration
  - Sexual and physical abuse
  - Domestic violence
  - Ethnic cleansing
  - Prisoners of war
  - Torture
  - Being held hostage

Disturbances in Self-Organization

- Affect dysregulation
- Negative self-concept
- Disorganized attachment patterns

In addition to symptoms of PTSD

Complex PTSD in ICD 11

PTSD

- Re-experiencing
- Avoidance
- Hyperarousal

Began January 1, 2022

Complex PTSD

- Re-experiencing
- Avoidance
- Hyperarousal
- Affect Dysregulation
- Negative Self-Concept
- Interpersonal Disturbances

YOU MUST ASSESS WHETHER YOU ARE DEALING WITH SIMPLE OR COMPLEX PTSD IN ORDER TO DEVELOP A TREATMENT PLAN!

The Complex Trauma Inventory (CTI)

- The CTI is a 20 item inventory (Litvin et al., 2017)
- It was developed to measure C-PTSD
- It measures both frequency and intensity of C-PTSD symptoms in six subscales
- These combine into two scales, PTSD and Disturbances in Self-Organization (DSO)
- The result is a composite score for PTSD
- It can be used to track changes in C-PTSD severity over time
- Interpretation guidelines are under development

Instructions for the CTI

(First, administer the Trauma History Screen [Carlson et al., 2011] or equivalent trauma history questionnaire)

After reading each symptom, think about how **ALL** the traumatic experience(s) you previously identified affected you within the past month. Please indicate (circle) how intense the following symptoms are AND how often you experienced the following symptoms **within the past month**:

	Intensity When you experience the symptom(s), how much do they bother you? (*Note*: Select "0" if it has not happened in the past month)					**Frequency** How often have the symptoms bothered you within the past month?					**Severity** Average the Intensity and Frequency Scores
Symptoms	Not at all	A little bit	Moderately	Quite a bit	Extremely	None	1-2 times a month	1-2 times a week	3-5 times a week	Daily or almost daily	(Intensity + Frequency)/2
1. Having bad dreams or nightmares about the traumatic event(s)	0	1	2	3	4	0	1	2	3	4	
2. Having to not talk/think about stressful experience(s) to minimize negative feelings	0	1	2	3	4	0	1	2	3	4	
3. Being "superalert" or on guard/watchful	0	1	2	3	4	0	1	2	3	4	
4. Being sensitive or having feelings easily hurt	0	1	2	3	4	0	1	2	3	4	
5. Feeling defeated or worthless	0	1	2	3	4	0	1	2	3	4	
6. Feeling distant from other people	0	1	2	3	4	0	1	2	3	4	
7. Feeling or acting as if you were reliving stressful experience(s) again	0	1	2	3	4	0	1	2	3	4	
8. Trying not to think about the traumatic experience(s)	0	1	2	3	4	0	1	2	3	4	
9. Feeling like you have to watch for dangers or threats	0	1	2	3	4	0	1	2	3	4	
10. Difficulty experiencing positive emotions (ex. unable to feel happy or feel love towards people close to you)	0	1	2	3	4	0	1	2	3	4	

The ICD 11 Trauma Questionnaire

- The ITQ is is an 18 item questionnaire (Cloitre et al., 2018)
- It was developed to measure C-PTSD in ICD 11
- It contains six questions for PTSD and six questions for DSO, measured by intensity, plus three questions for each measuring the intensity of the effects of the symptoms
- Results can be summed for PTSD and DSO scores

International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience _____

When did the experience occur? (circle one)

a. less than 6 months ago
b. 6 to 12 months ago
c. 1 to 5 years ago
d. 5 to 10 years ago
e. 10 to 20 years ago
f. more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
P5. Being "super-alert", watchful, or on guard?	0	1	2	3	4
P6. Feeling jumpy or easily startled?	0	1	2	3	4

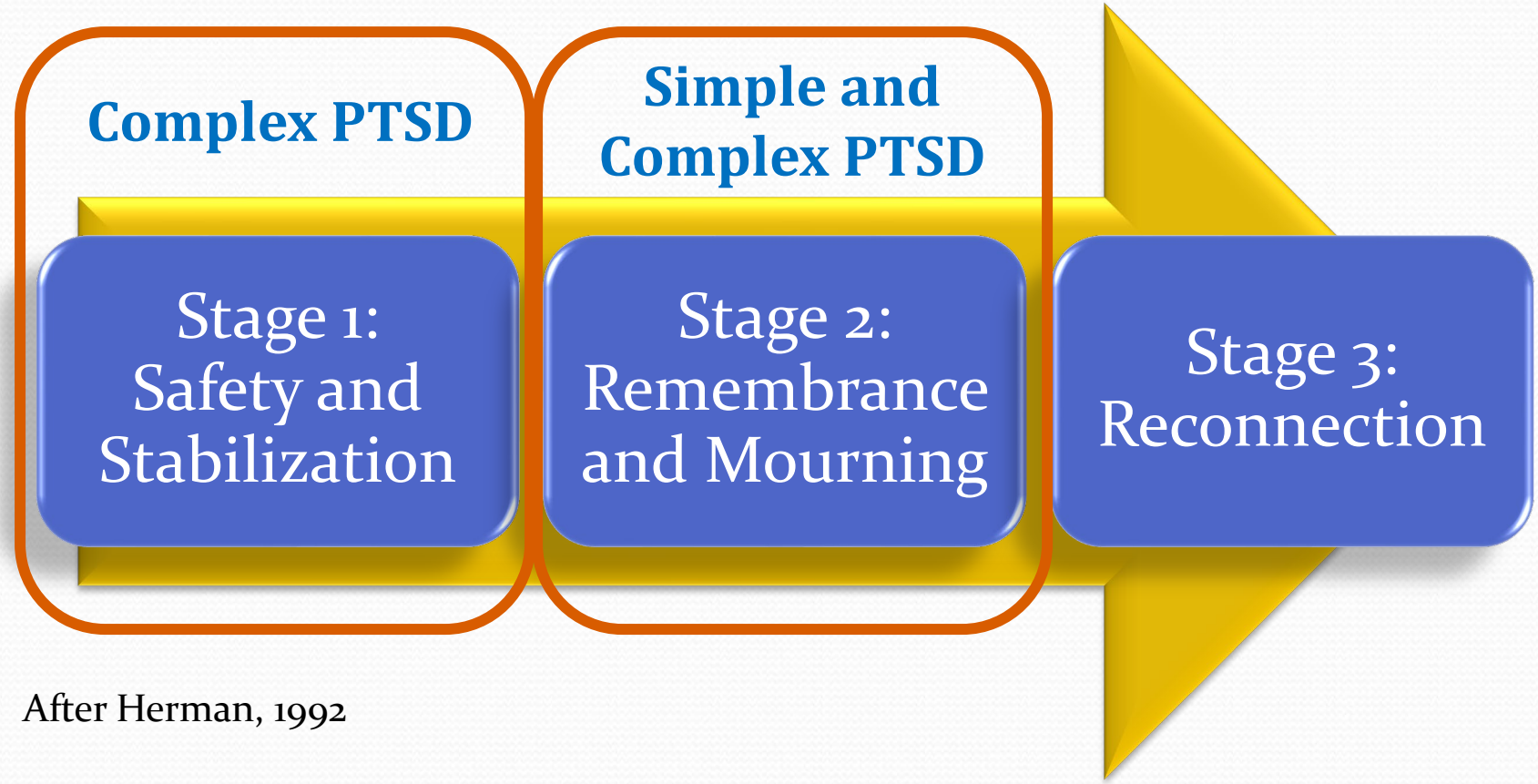
In the past month have the above problems:

P7. Affected your relationships or social life?	0	1	2	3	4
P8. Affected your work or ability to work?	0	1	2	3	4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Cloitre et al. (2018) *Acta Psychiatrica Scandinavica*. DOI: 10.1111/acps.12956

Evidence-Based Treatments for Stages I and II

Stages of Trauma Treatment



After Herman, 1992

Evidence-Based Treatments for Stage 1

Evidence-Based Treatments for Stage 2

- Cognitive Processing Therapy
- Prolonged Exposure
- Eye Movement Desensitization and Reprocessing

Treatments for Complex PTSD: Skills Training in Affective and Interpersonal Regulation for Stage I

Promising Treatments: STAIR Narrative Therapy

- Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy uses coping skills from Stress Inoculation Training and Dialectical Behavior Therapy (Cloitre et al., 2006)
- 8-10 sessions of skills building and 8 sessions of narrative therapy

Promising Treatments: STAIR

I. The resource of Hope: Introducing the client to treatment
II. The resource of Feelings: Emotional Awareness
III. Emotion regulation
IV. Emotionally engaged living
V. The resource of Connection: Understanding relationship patterns
VI. Changing relationship patterns
VII. Agency in relationships
VIII. Flexibility in relationships

Promising Treatments: Narrative Therapy

- Narrative Therapy: developing an autobiography
  - Repeated narration to organize trauma memory and reduce fear
  - Analyze meaning of event(s) to revise beliefs/schemas about self and others, integrate traumatic memories into a life history, and explore and resolve feelings other than fear
  - Continue practice of STAIR skills

Promising Treatments: Narrative Therapy

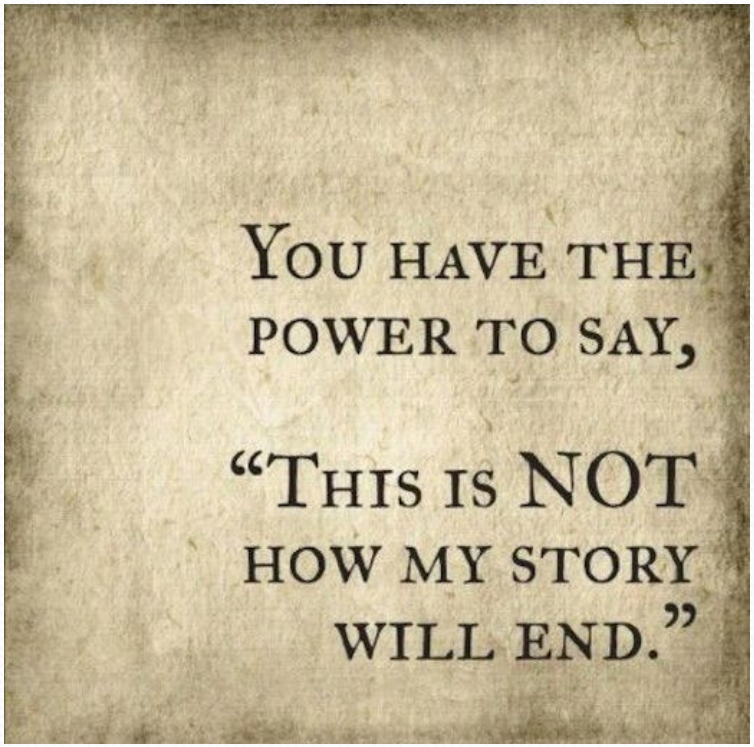
9. Introduction to Narrative Story Telling
10. Narrative of first memory

11 – 15 Narratives of fear

Narratives of shame

Narratives of loss

16. The last session



Promising Treatments: STAIR Narrative Therapy

- Balance between present-focused and past-focused treatments
- Targets emotion regulation, interpersonal problems, and PTSD
- Focuses on improving functioning
- First 8 sessions can be used as a precursor to CPT or PE
- This is the only Phase I and Phase II treatment for trauma and complex trauma

STAIR Narrative Therapy for C-PTSD

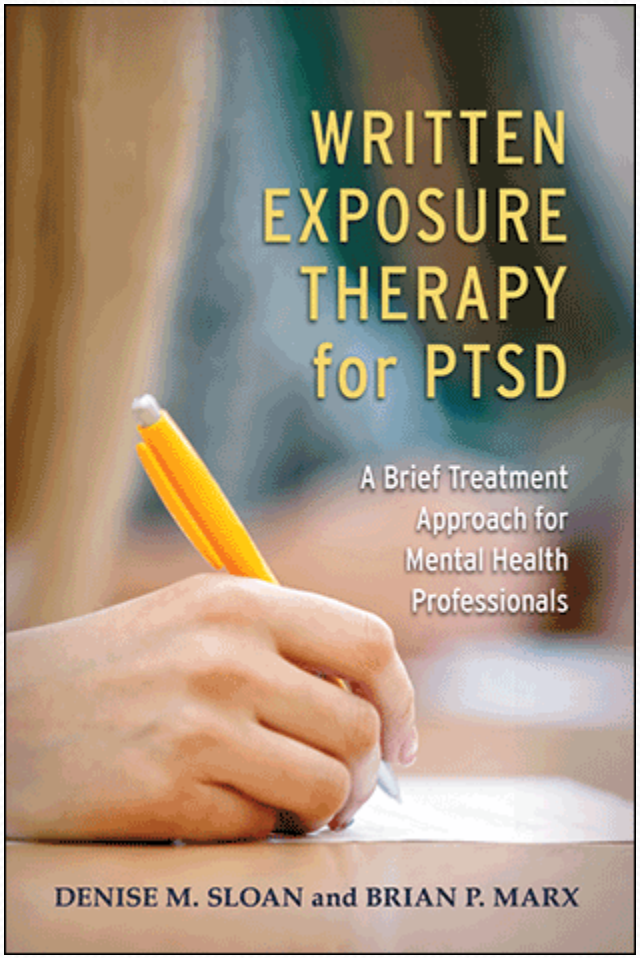
- Four studies of STAIR Narrative Therapy (Cloitre et al., 2002; Levitt et al., 2007; Trappler & Newville, 2007; Cloitre et al., 2010) show:
  - Decreases in PTSD symptoms
  - Improvements in interpersonal problems
  - Improvements in emotion regulation
- Studies of women with child abuse histories, post 9/11 survivors, inpatients with co-morbid PTSD and Schizoaffective Disorder, and female Veterans
- Works for Complex PTSD

Written Exposure Therapy: An Evidence-Based Treatment for Stage II

Written Exposure Therapy

- Five session therapy
- Each session contains 20 minutes of discussion and 30 minutes of writing by hand
- Structured writing process paying attention to thoughts and emotions
  - Written feedback given regarding fidelity to writing instructions
- Writing must be observed
  - Telehealth leads to distracted activities, increased dropout

WET Development



- Exposure works for PTSD via inhibitory learning (Craske et al., 2014)
- Trauma-related thoughts and beliefs change as a result of imaginal exposure (Aderka et al., 2013; McLean et al., 2015)
- Developed through a series of systematic studies on dose of writing, instructions given, etc.

WET Addresses Multiple Issues

- Length of treatment
- Homework burden
- Dropout rate
- Therapist burden
- Time to train therapist
- Cost to train therapist
- Client unwillingness to discuss details

Sloan & Marx, 2019

WET Sessions: Follow the Directions!

- First session provides psychoeducation and contains the first imaginal exposure
- The same event must be written about each time
- Directions must be read verbatim
- Clients must write for the full 30 minutes
- SUDs rating
- 10 minute discussion about what it felt like to write about the trauma
- Instruction not to avoid thoughts and feelings that come up

Sloan & Marx, 2019

Further Sessions

- Begin with a brief check-in about how client has been doing
- Therapist gives new directions next session based on on how well the client followed directions
- Third session includes direction to write about impact of the trauma
- Effects begin to show by the end of the third session
- Fifth session includes direction on how client wants to move forward in life

Sloan & Marx, 2019

What Patients Learn

- Intense negative emotion is tolerable
- Emotional distress decreases over time
- Distress associated with trauma memory passes
- Trauma memory can be experienced without significant distress
- Physiological responses (increased heart rate, sweating, etc.) are not dangerous
- New ways of thinking about traumatic memory and its meaning can develop

VA, 2021

Effectiveness

- WET vs. CPT (Sloan et al., 2018)
  - Dropouts: 6% vs. 40%
  - Equally effective at 6, 12, 14, and 36 weeks
- WET is effective (Sloan, Lee, et al., 2013; Sloan et al., 2018; Thompson-Hollands et al., 2018)
  - This includes two RCTs
- Recommended by VA/DoD as a first-line treatment for PTSD
- May double access to evidence-based treatment
- Can it be done in Primary Care?
- Can it be done in groups?

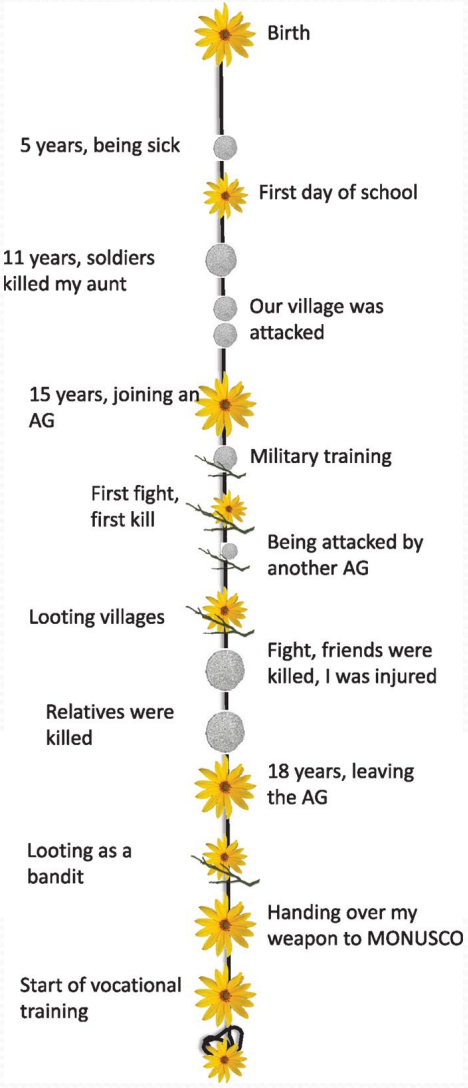
Treatments for Complex PTSD: Narrative Exposure Therapy, An Evidence-Based Treatment for Stage II

Narrative Exposure Therapy

- Designed for people with complex traumatic experiences (Schauer, Neuner, & Elbert, 2011)
- For small groups or individuals
- 4-10 sessions
- Focuses on developing a narrative for a person's entire life, not just their traumatic experiences

Narrative Exposure Therapy

- Participant tells the story of their life, including thoughts, emotions, and physiological responses while staying in the present
- Uses physical reminders (stones, flowers, etc.) to stay in the present
- Participant creates a lifeline
- Focuses on creating an account of what happens in a manner that emphasizes self-respect and acknowledges human rights
- Participants receive a written biography compiled by the therapist at the end of treatment



Narrative Exposure Therapy

- Designed for Complex PTSD
- Often used in community settings with groups such as refugees
- Can be delivered by laypersons
- There is a children's version called KIDNET
- NET is effective (Robjant & Fazel, 2010)
  - Further improvement at follow-up
  - Works in settings where violence continues

Virtual Reality: A Promising Treatment for Stage II

Virtual Reality for PTSD

- Began in 1990s
- An exposure treatment
- Used in Phase II of treatment
- Generally 6-20 sessions, average about 10-12
- Used by itself or as part of treatment programs
  - For example, Trauma Management Therapy, a 3 week IOP (Beidel et al., 2017)
- Emotionally engaging

What VR Looks Like

Virtual Reality

- Early work on Virtual Reality Exposure treatment case and pilot studies of 1-24 patients showed promise in reducing PTSD symptoms (Beck et al., 2007; Reger and Gahm, 2008; Rizzo et al., 2009; Reger et al., 2011)

Research on Virtual Reality

- 11 RCTs, many single group trials (pre-post)
- Populations include veterans and active duty military, disaster survivors, and World Trade Center survivors
- Compared to inactive controls, moderate positive effects
- Compared to active controls (e.g., other treatments including Cognitive Processing Therapy), results are non-inferior, showing no significant differences between treatments
- Lower dropout rates than CPT or PE (17%; Benbow and Anderson, 2019)
- There may be a dose-response relationship
- Results hold up at 6 and 12 months

Goncalves et al., 2012; Wenrui et al., 2019

Virtual Reality Advantages

- Prevents imaginal avoidance
- Makes exposure multi-sensory: images, sounds, and smells
- Allows exposure to situations that is not possible using in-vivo (live) method
- Can tailor exposures to an individual client's problems
- Can be used for different kinds of traumas
- Also works to significantly reduce co-morbid depression

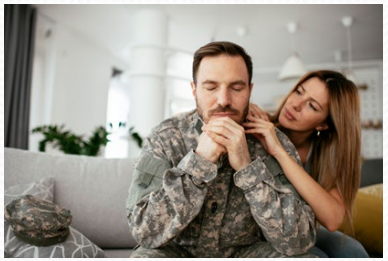
Virtual Reality Issues

- Sample sizes are small
- No standardized VR technology
- No standardized number of sessions (dosage)
- Not many studies on non-military populations
- Generalized settings vs. individualized ones
  - Difficulty of programming individual scenarios

Conjoint Behavioral Couples Therapy: A Promising Treatment for Veterans for Stage II

Rationale for CBCT

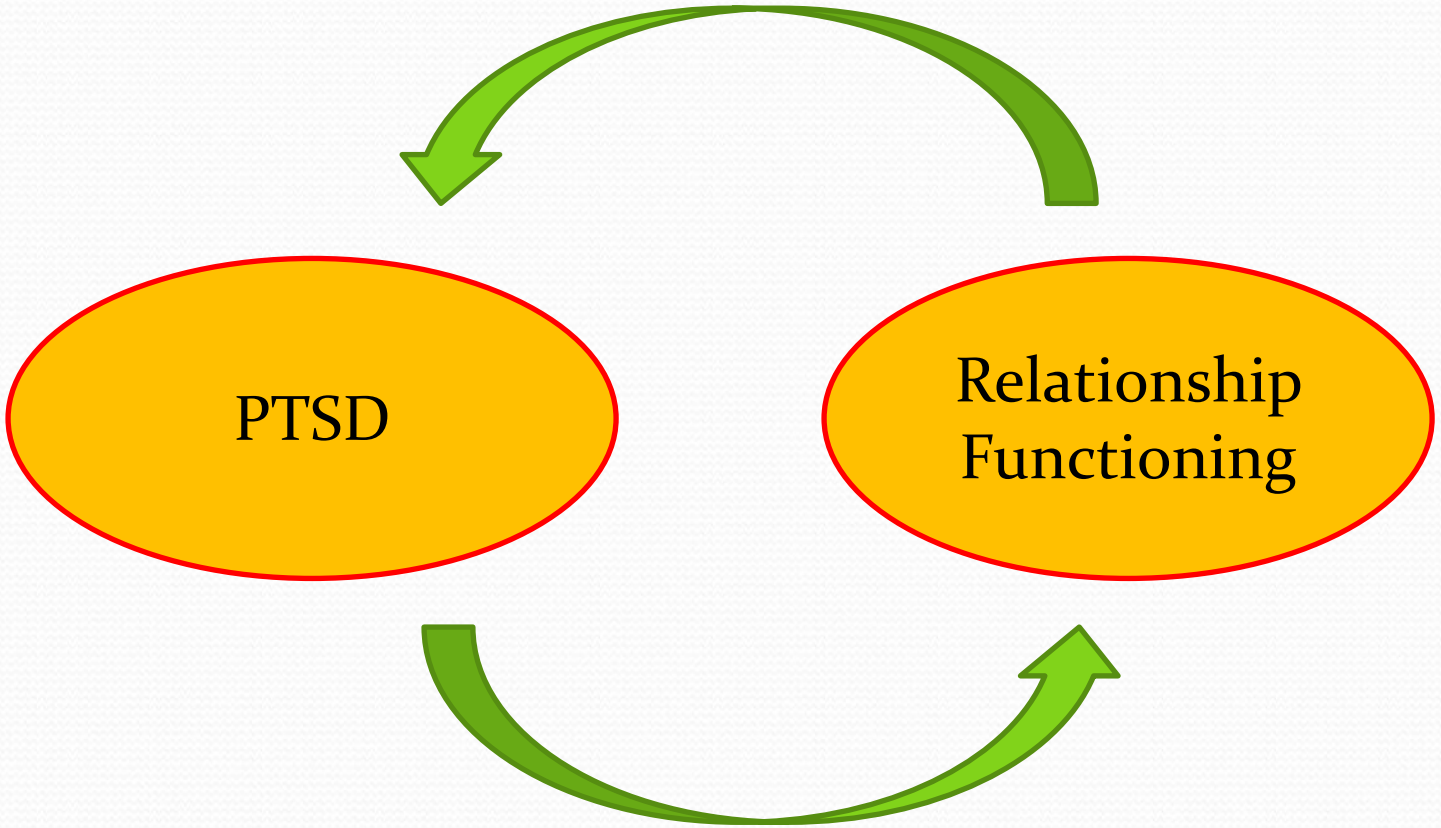
- Compared to Veterans who are trauma-exposed without PTSD, those with PTSD report:
  - More numerous and more severe relationship probles
  - More parenting problems
  - Poorer family adjustment
  - Higher rates of divorce



- The numbing and avoidance symptoms of PTSD are associated with intimate relationship dissatisfaction, impaired intimacy, and lower parenting satisfaction
- The hyperarousal symptoms are associated with aggression and interpersonal violence, especially when alcohol is involved
- Often partners have their own MH problems

Galovski & Lyons, 2004; Monson et al., 2009; Monson et al., 2012

The Reciprocal Relationship between PTSD and Couples Functioning



Cognitive-Behavioral Conjoint Therapy for PTSD

- Cognitive-Behavioral Conjoint Therapy for PTSD (CBCT) addresses both PTSD and associated relationship problems (Monson and Fredman, 2012)
- Three sessions of couple assessment
- Manualized treatment with 15 sessions of 75 minutes each
- The relationship is the patient
- Homework assignments
- 10,000 foot view of trauma
- Externalizes PTSD problems

Three Phases of CBCT

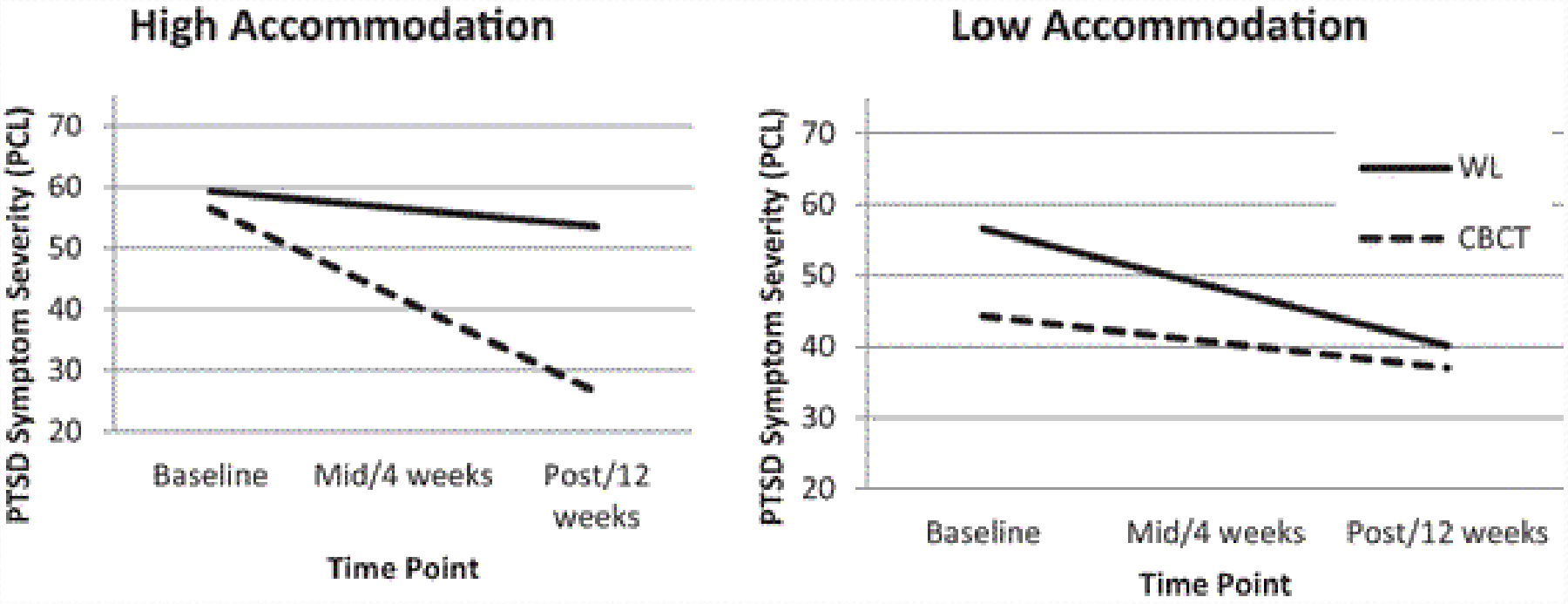
Rationale and Education	• Introduction, psychoeducation about the relationship between PTSD and relationship problems, and building safety (2 sessions)
Communication Skills Training	• Relationship enhancement and undermining avoidance (5 sessions) • Teach communications skills • Approach assignments
Meaning Making	• Dyadic cognitive interventions to address maladaptive thinking (8 sessions) • Reappraise traumatic events, present day beliefs, and relationship issues

Monson, Fredman, & Riggs, 2012

Research on CBCT for PTSD

- Studies of CBCT for PTSD in Veterans from different eras (Monson et al., 2004; Monson et al., 2011; Monson et al, 2012; Schumm et al., 2013) show:
  - Decreased PTSD symptom severity
  - Decreased depression, anxiety, and anger
  - Increased relationship satisfaction
  - Improved well-being of partners
  - Results maintained at 3 month follow-up

The Impact of Partner Accommodation



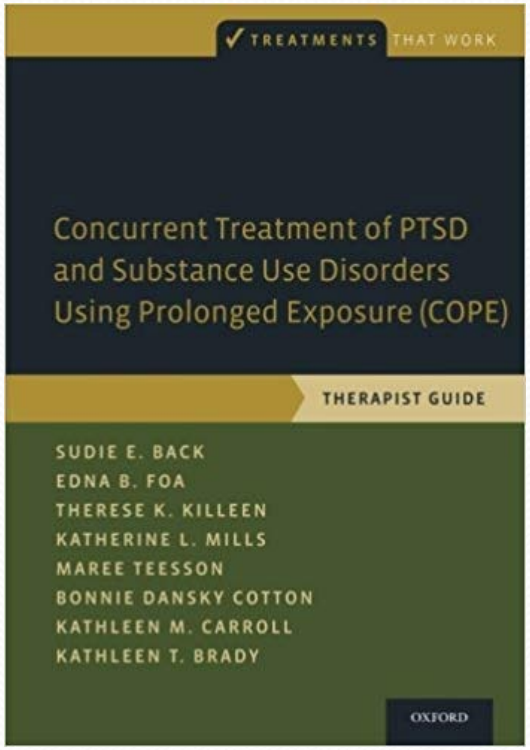
CBCT works better when the partner initially accommodates the Veteran's PTSD more (Fredman et al., 2016)

CBCT Limitations

- Long period of treatment
- Few studies
- Small sample sizes
- Most studies have been conducted by the creators of the treatment
- No research comparisons with evidence-based treatments for PTSD

COPE: An Evidence-Based Treatment for Co-Occurring PTSD and SUDs for Stages I and II

COPE

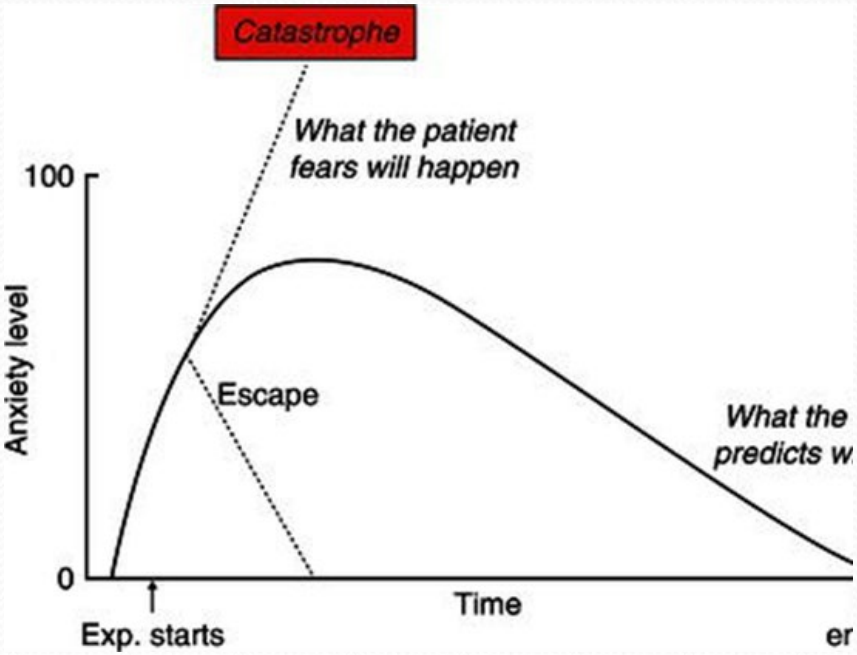


- Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE) is an integrated treatment in which both PTSD and SUD are treated by the same clinician (Back et al., 2015)
- COPE combines CBT for SUDs (Carroll, 1998; Kadden et al., 1992) and Prolonged Exposure (Foa et al., 2007)
- 12 90 minute sessions

COPE

- Education about the relationship between PTSD and SUD
- Education about common reactions to trauma
- Techniques to manage cravings and thoughts about using substances
- Coping skills to prevent relapse

COPE



- Breathing retraining
- Repeated in vivo exposures to safe situations
- Repeated imaginal exposure to the trauma memories

COPE Session Structure

- Review current PTSD symptoms and any substance use since previous session
- Review homework
- 45-60 minutes of PTSD material
- 30 minutes on substance abuse
- Assign homework

COPE Research

- Several studies of COPE show mixed results
  - One study found that integrated exposure therapy plus SUD treatment improves trauma symptoms but not substance abuse, depression or anxiety compared to TAU (Mills et al., 2012)
  - A second found that Prolonged Exposure plus Naltrexone does not improve trauma symptoms more than treatment as usual (Foa et al., 2013)
  - A third found that COPE and Relapse Prevention Therapy decreased PTSD symptoms by a similar amount (Ruglass et al., 2017)

A Promising Treatment for Complex PTSD: Dialectical Behavior Therapy-Prolonged Exposure for Stages I and II

The DBT Prolonged Exposure Protocol

- Trauma and PTSD are highly common in clients in DBT programs (Harned et al., 2008)
  - PTSD is unlikely to remit during DBT treatment
  - 87% of clients with PTSD still had it after one year
- DBT PE was developed by Melanie Harned, who had trained with Marsha Linehan, developer of DBT
- She enlisted the consultation of both Linehan and Edna Foa, the developer of Prolonged Exposure

DBTPE

Patient Population

PTSD

Clients have typically experienced multiple, often chronic traumas starting in childhood.

High-Risk Behavior

Clients engage in life-threatening and other impulsive, self-damaging behaviors.

Multi-Diagnostic

Clients have multiple, often severe mental disorders in addition to PTSD.

Difficult to Treat

Clients usually have difficulty attending, collaborating, and staying engaged in therapy.

Severe Disability

Clients typically exhibit severe impairment that makes it difficult to fulfill normative social roles.

DBT PE Stages

Stage 1 – Achieving safety, stability, and skills	• Standard DBT – Weekly individual therapy, Skills Training group, and phone coaching • Usually about 6 months
Stage 2 – Treating PTSD	• Receives standard DBT as above • Also receives DBT PE protocol in weekly 90-120 minute sessions • 3/4 complete it in an average of 13 sessions
Stage 3 – Treating remaining problems in living	• Receives standard DBT

Harned, 2022

DBT PE Readiness Criteria

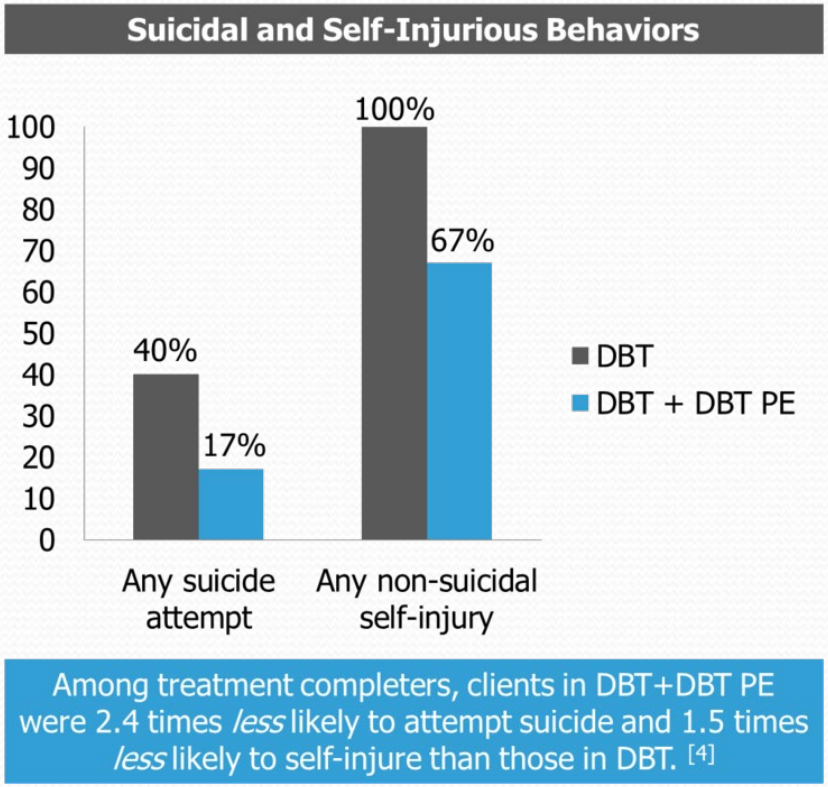
1. Not at imminent risk of suicide
2. No recent suicidal or self-injurious behavior
3. Able to control suicidal and NSSI behaviors in the presence of triggers
4. No serious therapy-interfering behaviors
5. PTSD is the client's highest priority target
6. Ability and willingness to experience intense emotion with trying to escape

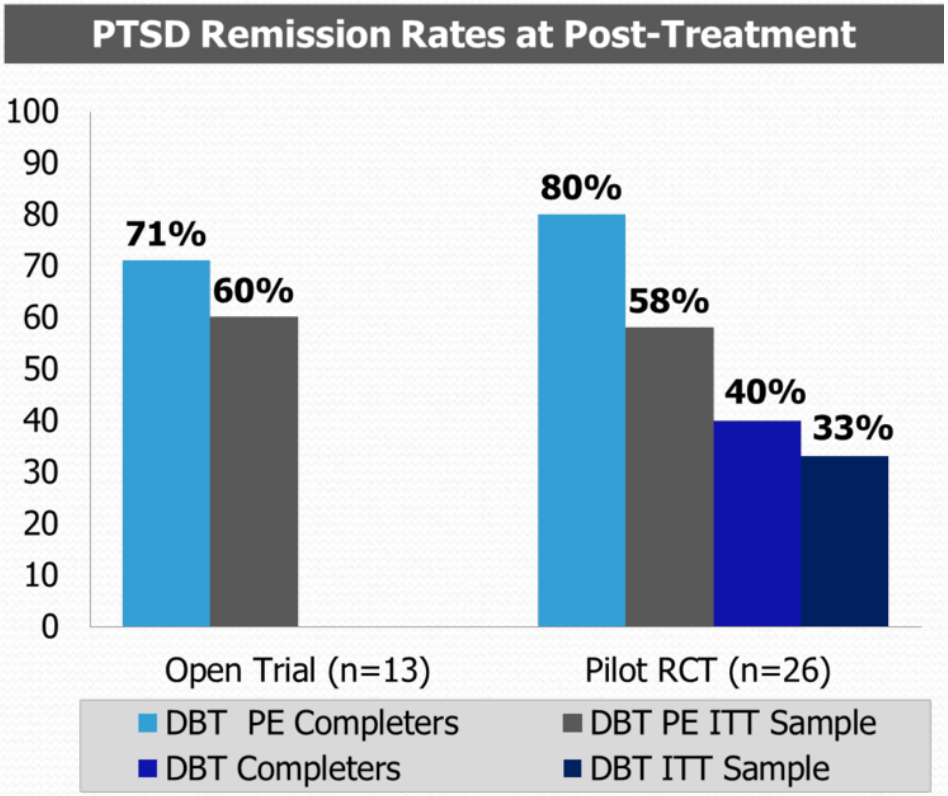
Harned, 2022

DBT PE Protocol

- Sessions include both DBT and PE elements
- DBT diary card is used
- Homework is reviewed early in sessions and assigned at the end
- In vivo exposure in early sessions, imaginal exposure in later sessions (the majority)
- Processing through acceptance, change, and dialectical strategies
- Final session includes teaching of Relapse Prevention and Management skills for PTSD

DBT PE Results





Harned, Korslund, et al., 2012; Harned, Korslund, & Linehan, 2014;

DBT PE Comments

- Safe
- Effective
- Can be used in community settings (Veterans, community care)
- Only 5 studies
  - Only one RCT
  - Only one conducted by a person other than creator of DBT PE
  - Most studies had small sample size (13-35 people), except for one community study of 241 clients

Harned, 2022

When to Use Which EBT

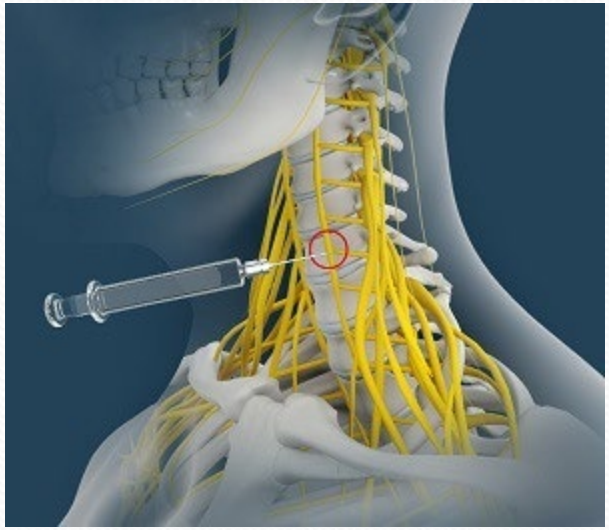
	PTSD	C-PTSD	BOTH
Stage 1		DBT STAIR	SS
Stage 2	PE WET VR CBCT	NET DBT PE	CPT EMDR COPE

Treatments for PTSD That Have Not Worked

Medical Treatment of PTSD: Stellate Ganglion Blocks

- The stellate gan… nerve cell … cated at the 7th cervical vertabrae
- A stellate ganglion b… …c injection through the front of the neck ty… …d for pain
- Recent case studies of ste… …lion blocks (2-9 patients) have suggeste… …locks may help rapidly reduce PTSD sympto… … Mulvaney et al., 2010)
- Why this might w… …stellat… …on block may stop Nerve Gr… …ctor associa… …stress from increasing norepinephrine levels associated with PTSD (Lipov and Kelzenberg, 2012)
- Larger scale trials are now underway

Medical Treatment of PTSD: Stellate Ganglion Blocks



- Study of 42 military service members with PTSD (McLay et al., 2015)
- 27 received SGBs and 15 received sham injections
- PTSD symptoms improved for both groups
- There was no significant difference between the SGB group and the sham treatment group

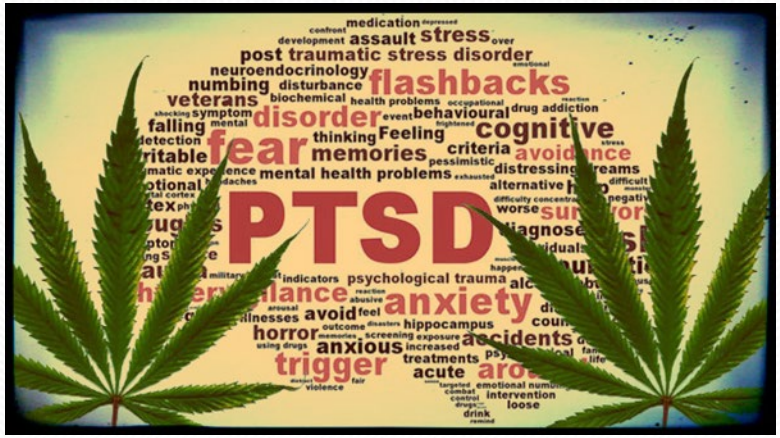
Summary: the evidence is not conclusive

Medical Marijuana

- Some Veterans with PTSD claim that marijuana is the only thing that helps their PTSD
  - Some Veterans are lobbying Congress to allow the VA to prescribe medical marijuana
- There is little research evidence for this claim
  - The first major studies are currently being conducted
  - Of the first four, only one has shown any positive effects

Medical Marijuana

- Marijuana contains a complex mixture of cannabinoids
- Marijuana can increase PTSD symptoms, particularly paranoia
- Marijuana has other negative effects, such as increasing the likelihood of a psychotic break



Medical Marijuana

- A recent observational study of more than 2,000 Veterans in PTSD treatment programs (Wilkinson, 2014) found:
  - Those who never used marijuana had significantly less severe PTSD symptoms than those who had used it or started using it after beginning PTSD treatment
  - Those who used marijuana when they started treatment but stopped using it after the conclusion of treatment also had significantly less severe PTSD symptoms than those who continued to use it
  - Those who started using marijuana after the conclusion of treatment had the highest levels of violent behavior

Does Cannabis Treat PTSD?

There is no current scientific evidence that *the cannabis plant* is an effective treatment for PTSD. What we have:

- Anecdotal evidence from cannabis users that drug helps with PTSD
- Preclinical studies testing a specific pharmaceutical cannabinoid
- Few studies of pharmaceutical cannabinoids in humans
- Case studies
- No randomized controlled trials studying the cannabis plant
- Long term effects are largely unknown

Browne, 2019

Problems with Cannabis Research

- Most of the research is on pharmaceutical cannabinoids, not the cannabis plant
- The amount of THC varies from plot to plot and year to year
- Labels of dosages of cannabinoids are inaccurate
- Route of administration varies
- Proportions and amounts of THC varies
- Quantity consumed varies
- Frequency of use varies
- There's very little high quality research

Bonn-Miller et al., 2013; Browne, 2019; Crippa eta al., 2009; Vandrey et al., 2015; WHO, 2016

Psilocybin

- Recently Psilobycin has been proposed as a treatment for PTSD
- There is very little published material on the subject
- There are case studies and small sample studies
  - Mostly funded by institutes interested in psychedelics
- No RCTs or longitudinal studies
- Risk of poisoning, especially if self-administered
- Unresolved questions:
  - Nature of monitoring
  - No standardization of treatment length or content
- Caveat emptor: let the buyer beware

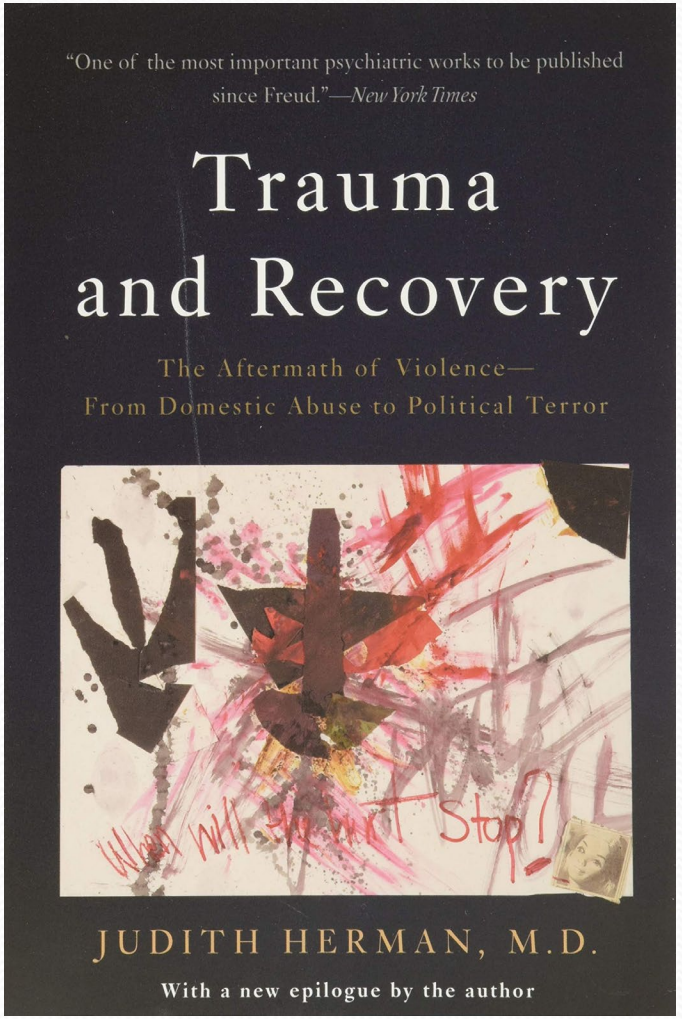
Resources

Resources for PTSD

- National Center for PTSD: www.ptsd.va.gov
- International Society for Traumatic Stress Studies: www.istss.org
- International Society for the Study of Trauma and Dissociation: www.isst-d.org
- PTSD 101 courses: www.ptsd.va.gov/professional/ptsd101/course-modules.asp

Resources for Complex PTSD

- *Trauma and Recovery* (1993), Judith Herman
- *The Trauma Recovery Group: A Guide for Practitioners* (2011), Michaela Mendelsohn, Judith Herman, Emily Schatzow, and Diya Kallivayalil



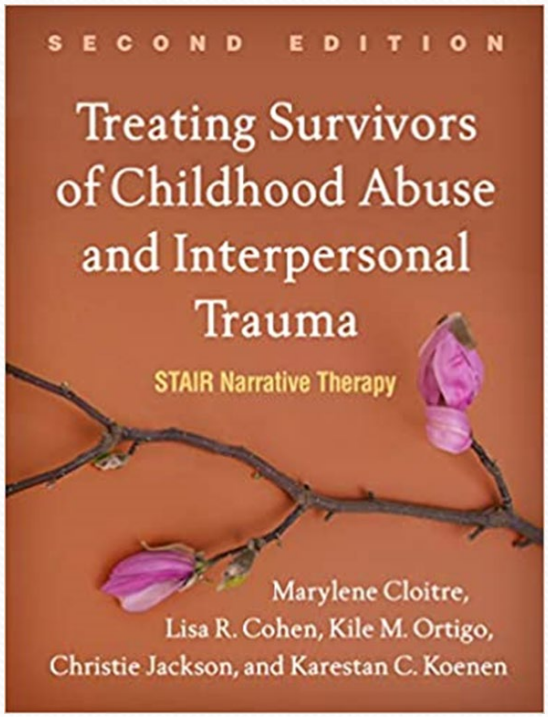
Complex Trauma Resources

- *Treating Complex Traumatic Stress Disorders* (2009), Christine Courtois and Julian Ford, eds.
- *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models* (2013), Christine Courtois and Julian Ford, eds.
- *Treatment of Complex Trauma: A Sequenced, Relationship-Based Approach* (2012), Christine Courtois, Julian Ford, and John Briere

Complex Trauma Resources

- Luxenberg, T., Spinazzola, J., and van der Kolk, B. (2005). Complex Trauma and Disorders of Extreme Stress (DESNOS) Diagnosis, Part One: Assessment (2005). Directions in Psychiatry, 21, 373-393.
- http://www.nctsn.org/trauma-types/complex-trauma/assessment
- www.acestudy.org

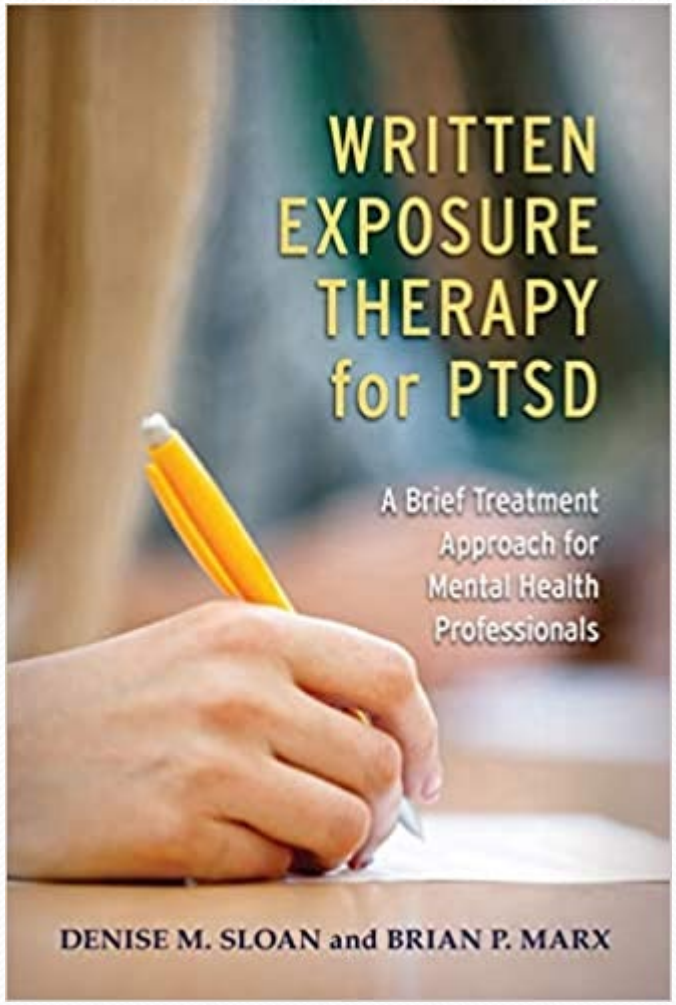
STAIR Narrative Therapy



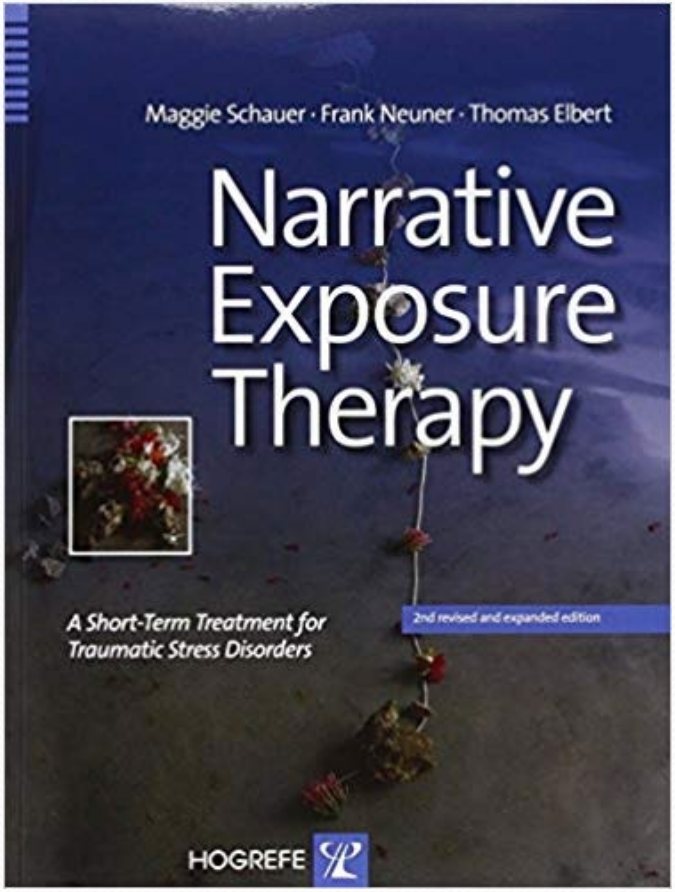
- *Treating Survivors of Childhood Abuse and Interpersonal Trauma: STAIR Narrative Therapy, 2nd ed.* (2020), Marilene Cloitre, Lisa Cohen, Kile Ortigo, Christie Jackson, and Karestan Koenen
- Online at http://www.stairnt.com/index.html
- http://www.ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp

Written Exposure Therapy

- *Written Exposure Therapy for PTSD* (2019), Denise Sloan and Brian Marx



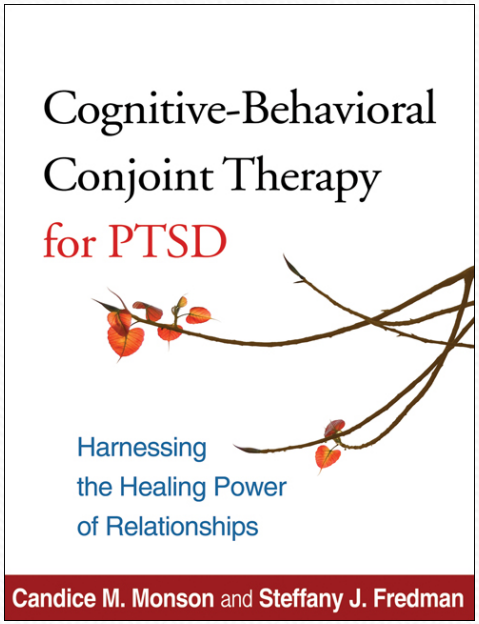
Narrative Exposure Therapy



- Narrative Exposure Therapy: A Short-Term Treatment for Traumatic Stress Disorders (2011), Maggie Schauer, Frank Neuner, & Thomas Elbert

Cognitive-Behavioral Conjoint Therapy for PTSD

- *Cognitive-Behavioral Conjoint Therapy for PTSD: Harnessing the Healing Power of Relationships* (2012), Candice Monson and Steffany Fredman
- https://www.ptsd.va.gov/professional/continuing_ed/cognitive_behavioral_conjoint_tx.asp
- https://www.coupletherapyforptsd.com/therapy/



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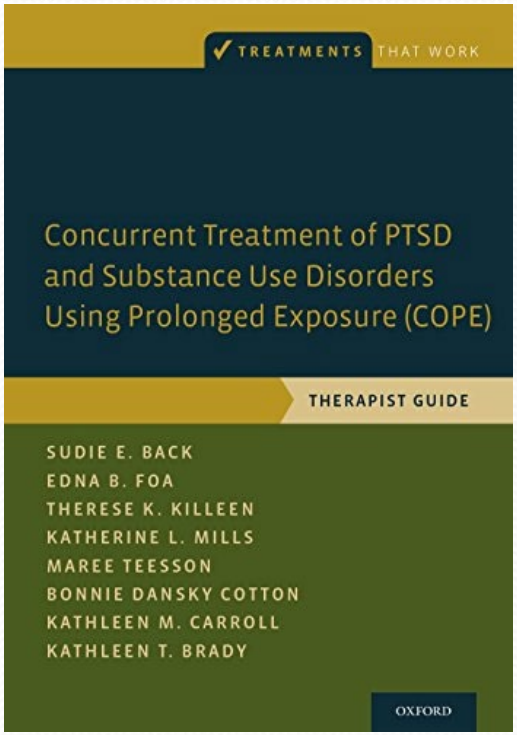
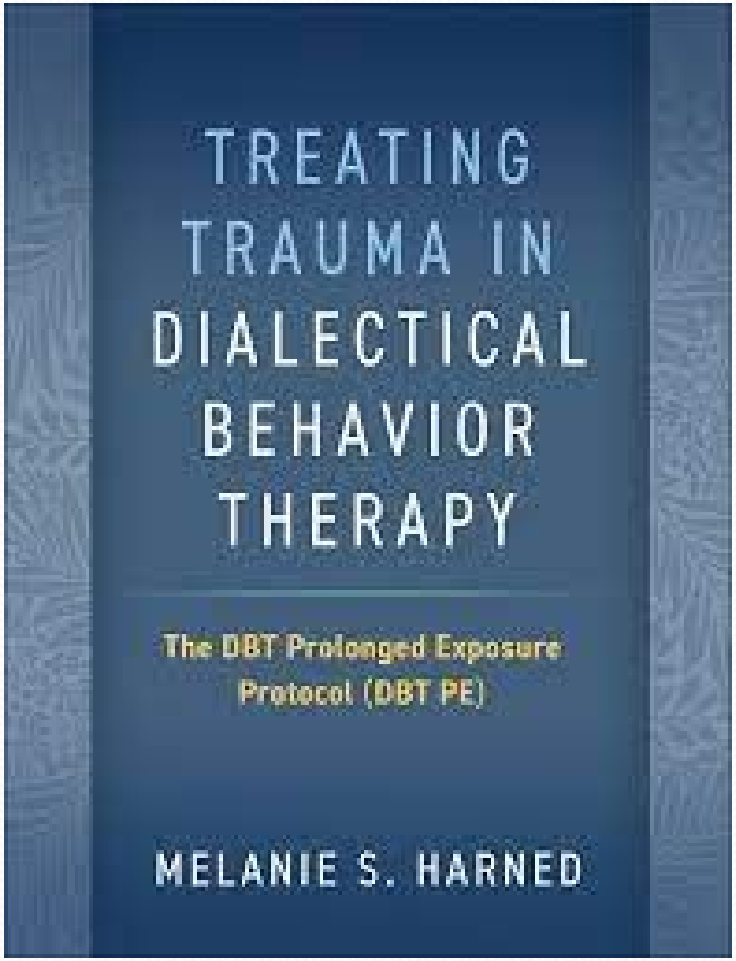


- Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE) Therapist Guide (2015) by Sudie Back, Edna Foa, Therese Killeen, Katherine Mills, Maree Teesson, Bonnie Cotton, Kathleen Carroll, and Kathleen Brady
- Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE) Patient Workbook (2015) by Sudie Back, Edna Foa, Therese Killeen, Katherine Mills, Maree Teesson, Bonnie Cotton, Kathleen Carroll, and Kathleen Brady

DBT PE

- *Treating Trauma in Dialectical Behavior Therapy (2022)* by Melanie Harned
- Website dbtpe.org



Online Resources

- Self-assessment Mental Health screening

http://www.militarymentalhealth.org/

- Problem-solving

http://startmovingforward.t2.health.mil/

- Wellness resources

http://afterdeployment.t2.health.mil/

Self-Help Mobile Applications

http://www.t2health.org/mobile-apps

- PTSD Coach

- PTSD Family Coach

- Breathe 2 Relax

- Tactical Breather

- LifeArmor (includes family section)

Mobile Applications That Assist Psychotherapy

- PE Coach

- CPT Coach

- CBT-I Coach

- Mindfulness Coach

Contact:

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